❑ **EXPEDITED REQUEST**
*If checked, return to DMHC *within 24 hours*

**STATE OF CALIFORNIA**
**DEPARTMENT OF MANAGED HEALTH CARE**
# INDEPENDENT MEDICAL REVIEW PROGRAM
# REQUEST FOR HEALTH PLAN INFORMATION (RHPI)

The Department of Managed Health Care (DMHC) has received a request from a Health Plan enrollee for an Independent Medical Review (IMR) related to the following health care service dispute: (Example: Denial for Physical Therapy)

Disputed medical service or treatment: _____

Name of Enrollee: _____ Enrollee Address:_____
Membership ID#/SSN _____ Enrollee DOB: _____
Plan coverage (HMO, POS, PPO, etc):_____

**In order to process the IMR application, DMHC is requesting additional information from the Enrollee's Health Plan. Please complete all information below:** ( Note: HP may submit additional information to DMHC to clarify the case.)

❑ Confirmation that the enrollee is actively eligible with the Health Plan. **Yes / No** Termination date:___/___/___

❑ Does the Plan agree this case is eligible for an IMR? **Yes / No**

❑ A copy of the Plan's denial letter(s) and final grievance response specific to the dispute noted above. (Please attach. If applicable, please attach relevant underlined segments of the Plan's Evidence of Coverage.)

❑ Please state specific reason for denial: _____
Include supporting documentation for the health plan's denial.

The Plan's reason for denial was based on which of the following determinations: (Check the box)

| | | | |
|---|---|---|---|
| Benefit Coverage | | Medical Necessity | |
| Experimental/ Investigational Treatment | | ER or Urgent Care Claim Denial | |

❑ Does treatment involve medication denial? **Yes / No**

❑ Does treatment involve mental health services denial? **Yes / No**

❑ Please provide the ICD - 9, CPT - 4 or other codes appropriate for the member's condition and requested services.
ICD - 9 code(s): _____ CPT - 4 or other service codes: _____

❑ Are the medical services requested or rendered, in-network or out-of-network? _____

❑ Has the treatment been rendered to the enrollee? **Yes / No**

❑ If an Urgent/ER reimbursement denial, the health plan shall identify and provide the specific facts, records or portions of the records upon which it relied, a complete and legible copy of all medical records pertaining to the denial, and a copy of the reimbursement claim form.

❑ Please note the date the enrollee's grievance was received by the plan. ___/___/___.
❑ Please note the date the grievance was resolved. ___/___/___.
❑ Was the grievance expedited? If Yes, Briefly Explain:_____

| | |
|---|---|
| ❑ Name of Medical group / IPA: | List names and specialties of physicians or clinical staff involved in ***Utilization Management Review*** of this case. |
| ❑ Name and specialty of treating physician: | |

❑ If a Medi-Cal provider, list the provider number:_____
❑ Is the Enrollee a Medicare beneficiary? **Yes / No**
❑ Is the Enrollee covered under a Medi-Cal Managed Care Product? **Yes / No**
❑ If Medi-Cal, has the enrollee filed for a Fair Hearing? **Yes / No**

**DATE RHPI FAXED TO HEALTH PLAN: ____/____/____**
**DATE of HEALTH PLAN RESPONSE: _____/____/____**

***Important Response Times:*** **Health Plan response time back to DMHC for Expedited Requests is 24 Hours from date of fax. Health Plan response time back to DMHC for Standard IMR Requests is 2 business days from date of the fax.**

***Please Fax*** this form and attachments to DMHC: **Fax # (916) 229-4328** **ATTN:** _____
If you have any questions please contact: _____